Infant's Name _____Birth Date _____ Today's Date _____

_____Male _____Female Birth Weight _____ Present Weight _____ Birth Location_____

_____Vaginal birth _____C-Section Birth Any birth complications? _____

Are you presently breastfeeding _____Yes _____No If no, how long since you stopped breastfeeding _____

Medical History:

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ____Yes ____No
2. Was your infant premature? ____ Yes ____ No If Yes, how many weeks? _____
3. Does your infant have any heart disease ____ Yes ____ No or known bleeding diseases? ____Yes ____ No
4. Has your infant had any surgery? ____ Yes _____ No
5. **Has your infant experienced any of the following? Please check / circle / elaborate as needed.**

____ Shallow latch at breast or bottle
____ Falls asleep in the middle of a feed
____ Slides or pops on and off the nipple
____ Gagging, choking, or coughing when eating
____ Poor or slow weight gain
____ Hiccups often ____ Lots of *in utero* hiccups
____ Gumming or chewing the nipple
____ Pacifier falls out easily or won't stay in
____ Snoring, noisy breathing, or mouth breathing
____ Short sleeping and waking often
____ Baby moves a lot in sleep/restless sleep
____ Baby seems always hungry and not full

____ Lip curls under when nursing or taking bottle
____ Clicking or smacking noises when eating
____ Sucking blisters or callouses on lips
____ Colic symptoms / Baby cries a lot
____ Reflux symptoms
____ Spits up often? Amount / Frequency_____
____ Gassy (toots a lot) / Fussy often
____ Milk leaks out of mouth when nursing/bottle
____ Nose sounds congested often
____ Baby is frustrated at the breast or bottle
How long does baby take to eat? _____
How often does baby eat? _____

6. Is your infant taking any medications? ____ Reflux _____Thrush Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

_____

7. Do you have any of the following signs or symptoms now or in the past? Please check/circle/elaborate.

____ Creased, flattened, or blanched nipples
____ Lipstick shaped nipples
____ Blistered or cut nipples
____ Bleeding nipples
Pain on a scale of 1-10 when first latching _____
Pain (1-10) during nursing _____

____ Poor or incomplete breast drainage
____ Decreasing milk supply
____ Plugged ducts / engorgement / mastitis
____ Nipple thrush
____ Using a nipple shield
____ Baby prefers one side over other _____ (R/L)
____ Feelings of hopelessness / depression

Primary Care Provider _____ Chiropractor/PT/CST_____

Lactation Consultant _____ Other Therapist/Provider_____

Who referred you to us? _____ How far away do you live? _____

Doctor's Signature _____